Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TRIUMPH HOSPITAL OF NORTH HOUSTON
C/O HOLAWAY & GUMBERT
3701 KIRBY DR SUITE 1288
HOUSTON TX 77098

Respondent Name

AMERICAN CASUALTY CO OF READING

Carrier's Austin Representative Box

Box Number: 47

MFDR Tracking Number

M4-04-9025-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier paid a total of $900.00 in connection with the claim alleging payment to be 'fair and reasonable.' It is our position that reimbursement was neither fair nor reasonable pursuant to Rules 134.401(a)(4) and 134.600 of the Texas Workers' Compensation Commission ('TWCC'). Fees for goods and services provided by Triumph Hospital of North Houston are based upon the rates that the market will bear in the geographic locale of the hospital... Our client's rates for the goods and services it provides are similar to and competitive with other general hospitals in the greater Houston, Texas area. It is our contention that reimbursement by the carrier at a rate of approximately forty-nine (49%) of the Hospital's standard charges does not constitute 'fair and reasonable' reimbursement, especially in light of the hospital setting the services were provided in and the sedation and anesthetic provided for the patient."

Amount in Dispute: $955.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Carrier, or its agent, did not respond to the request for medical fee dispute resolution, received by the Carriers' representative on May 4, 2004, or the additional information, received by the Carriers' representative on June 3, 2004.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2003	Outpatient Surgery	$955.23	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on April 30, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on May 10, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M – No MAR
   - (855-056) – Outpatient procedures or surgeries of 30-60 minutes in O/R.
   - 1 – No MAR. Outpatient treatments of 30-60 minutes in the OR are paid not to exceed inpatient setting and per section 413.011(B) of the Texas Workers' Compensation Act.
   - 2 – Charges exceeds usual and customary.
   - O – Denial after reconsideration.
   - (920-002) – In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.
   - G (3) – Unbundling.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report and sedation record, the requestor did not submit a copy of the post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "reimbursement was neither fair nor reasonable pursuant to Rules 134.401(a)(4) and 134.600 of the Texas Workers' Compensation Commission ('TWCC'). Fees for goods and services provided by Triumph Hospital of North Houston are based upon the rates that the market will bear in the geographic local of the hospital... Our client's rates for the goods and services it provides are similar to and competitive with other general hospitals in the greater Houston, Texas area. It is our contention that reimbursement by the carrier at a rate of approximately forty-nine (49%) of the Hospital's standard charges does not constitute 'fair and reasonable' reimbursement, especially in light of the hospital setting the services were provided in and the sedation and anesthetic provided for the patient."
   - The requestor did not submit documentation to support that the fees for goods and services provided by Triumph Hospital of North Houston are based upon the rates that the market will bear in the geographic locale of the hospital and that the rates for the goods and services it provides are similar to and competitive with other general hospitals in the Houston, Texas area.

- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 23, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.